New Jersey
Child Welfare Panel

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Briefing on Priority Issues In Child Welfare Reform

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Nature and Purpose of This Document

This briefing presents preliminary findings and conclusions of the New Jersey Child Welfare Panel on the State's progress during the period July-December 2005 in critical areas of its child welfare reform plan. Over the past few weeks the Panel has briefed the new leadership of the Department of Human Services on these findings, in an effort to make sure that the information we have gathered is available quickly to those who are now charged with directing the reform effort. We have provided a similar briefing to the lawsuit plaintiffs, Children's Rights. Both parties have agreed that it would be useful for the Panel to make this information available in writing so it can be more widely understood and used.

It should be clear from the outset that this is not a monitoring report, as defined in the Settlement Agreement. It does not include data on outcomes for children and families, which the Panel expects to receive and analyze within the next month, and it does not address several significant parts of the reform plan. Instead, it focuses on six priority areas. We selected these areas, with the concurrence of the parties, because of their immediate impact on the lives of children in the system and their families; because of their importance to the overall reform effort; and because there have been significant problems in these areas in the past. The areas are:

1. Reducing caseloads
2. Training staff and supervisors
3. Screening allegations of abuse and neglect and initiating prompt investigations
4. Improving adoption practice
5. Recruiting, training, supporting, and retaining resource families for children who need out-of-home placement
6. Providing timely and effective medical services for children in out-of-home care

In each area, we set forth in summary form: major conclusions with regard to the State's progress from July through December of 2005; relevant data; other important information about the work done during this period; and our preliminary thoughts on actions that the new leadership should consider in moving forward.

Overview and Major Conclusions

As has been the case in prior periods, we find that the State's performance in these critical areas during the last six months of 2005 was well short of what the public and the Court could reasonably expect. Indeed, in some areas, where prior shortcomings could be explained in part by the amount of time needed to lay the groundwork for future improvements, the record compiled from July through December is particularly disappointing.

Problems of note include the following:

- Despite an enormous investment in staff to recruit, train, and support resource families, the number of licensed non-relative families *decreased* by 90 from the end of June to the end of December 2005; for calendar year 2005 as a whole, this figure decreased by 163.
- The caseloads of workers assigned to child protection units—investigators and assessors-- *increased* during this period. Compared to the beginning of the period, by the end of December, a higher percentage of these intake workers had more than twelve open cases, and a higher percentage had more than eight new investigations assigned during the month. Caseloads of permanency workers

declined only very slightly, as did the number of permanency workers with extraordinarily high caseloads of 30 or more families.

- The very limited data available strongly suggest that most children entering out-of-home care in 2005 did not receive a comprehensive medical and mental health examination, nor is there documentation of routine provision of services for children who needed follow-up treatment.
- The number of cases referred for investigation increased rapidly, apparently because of a breakdown at the centralized hotline rather than a surge in calls.[1] Workers in the field report confusion about why some cases are referred for investigation and being overwhelmed by the number of new investigations.

In other areas covered by this briefing report, the picture is mixed. A new pre-service training curriculum represents improvement over the training previously provided, but it encountered significant challenges in implementation. Neither current supervisors nor experienced workers had been offered re-training by the end of the period. The State made progress in implementing its interim adoption plan, but more than 700 children were still assigned to workers without sufficient adoption expertise or support to properly assist them. Almost 2,500 children are legally free for adoption; about half of them need active recruitment of adoptive families and progress during 2005 in recruiting adoptive homes appears to have been minimal.

Before turning to more detailed information about these priority issues, we think it useful to identify a set of cross-cutting themes that we believe help to explain the State's limited progress in implementing the reform plan. In our view, sustained attention to these broader concerns by the new leaders is essential to achieving success in any of the specific issue areas. These themes have been noted in past Panel reports, but we believe they are worth reemphasizing. They are:

1. *The need for stronger leadership and much clearer assignment of responsibility in key areas of the plan*

In several of the priority areas, unclear lines of authority and accountability have been important factors limiting the State's progress. In several instances there have also been multiple transitions of leadership within a very short period of time. The creation of a strong and stable leadership team with clear assignment of responsibility is an essential starting point for successful implementation of the reform plan.

2. *The need for more effective, two-way communication between leadership in Trenton and the field*

Particularly apparent in the last six months of 2005 was the lack of effective communication within DHS and OCS and between state level leadership in Trenton and mid-level administrators and line workers in the field offices. Most communication was top down, and the continually changing nature of directives and priority actions has left the field offices confused and exhausted. Opening up more consistent and effective lines of two-way communication so that the system as a whole can openly and honestly understand both its strengths and weaknesses must be a high priority for future success of the reform.

3. *The need for integration of parts of the system that often work in isolation from one another*

Many of the individual problem areas noted above reflect the lack of integration of different parts of the child welfare system reform. Too often we have seen parts of the work that should be coordinated occur

[1] Preliminary information suggests that there has been a further increase in January 2006.

in isolation or sometimes even in conflict with each other. Examples include the lack of connection between staff charged with resource family recruitment and the community collaboratives funded in part to help recruit and support resource families, and the continuing difficulties in making appropriate behavioral health system resources available for children and families served by DYFS.

4. *The need for a clear statement of the kind of case practice the Department is committed to providing for every child and family in its care and the skills workers and supervisors need to deliver this practice*

The reform plan is based on a set of basic principles that should guide all aspects of child welfare practice in New Jersey. These principles ought to drive, for example, decisions about new policies; about the skills needed by front-line staff and supervisors and the kind of training that will help them develop those skills; and about how the Department makes services available to help children and families. But the practice model underlying the reform plan is not yet well understood or shared by all parts of the system. A clear explanation of the practice principles and their implications is a necessary prerequisite for progress in many of the individual action areas.

Finally, this briefing report underscores that much of the slow progress and problems that we have identified are due to failures of implementation rather than failures of vision. We urge the new leadership to focus its initial efforts on understanding and correcting the serious implementation problems encountered to date, rather than re-visiting the concepts that underlie the reform plan. An effort to focus resources and help as quickly as possible on the front lines will, in our view, do far more to produce better results for children and families than a return to conceptual planning.

Caseload Reduction

Overall: Caseload reduction has been a high and visible priority. As of the end of December 2005: (1) Caseloads of intake (child protection) workers were worse than six months earlier, and there was only slight progress in reducing caseloads of permanency workers. (2) Even these findings are clouded by the findings of caseload audits which indicate reasons to doubt the accuracy of the Department's caseload data and the validity of future projections. Materials previously submitted by the State projected that workers would reach target caseloads later than originally expected but by September 2006; this projection does not seem realistic with current hiring plans and existing caseload reduction strategies. (3) Problems at the hotline and with investigative policy and practice partly explain limited progress and suggest further difficulties ahead.

Data (comparisons are December 2005 vs. June 2005 unless otherwise indicated):

The percentage of permanency workers at the caseload standard— no more than 15 cases and no more than ten children in out-of-home placement--was 51%, up from 47% in June 2005. The number of permanency workers with more than 30 cases was down to 72 from 81. See Table I below.

Table I: Permanency Caseloads

Meeting Standard	June	July	Aug	Sep	Oct	Nov	Dec
Phase I (Final)	50%	48%	48%	50%	52%	55%	55%
Phase II (Final)	44%	45%	45%	48%	49%	49%	50%
Phase III (Final)	44%	41%	43%	41%	45%	44%	48%
Phase III (20 or less)	76%	73%	74%	74%			
Phase III (17 or less)					68%	67%	68%
Statewide (Final)	47%	45%	46%	47%	49%	50%	51%
# w/ over 30 cases	81	94	75	70	68	70	72

Note: The original caseload standard distinguished between counties in Phases I, II and III. The State has since ceased using the phase concept. The original December 31, 2005, enforceable is 95% meeting the standard except in Phase III counties, where 95% of workers are supposed to have 17 or fewer cases. By March 31, 2006, 95% of permanency workers across the entire State are supposed to have achieved the caseload standard.

The percentage of intake workers at standard for total caseload was *down* to 47% from 58% in July. The percentage of intake workers at standard for new investigations assigned was *down* to 75% from 90% in July. The number of intake workers with more than 30 cases, was 33, down from 84 in June. See Table II below. Importantly, the number of cases reported as unassigned to *any* worker was *up* to 700 from 550.

Table II: Intake Caseloads

	July	Aug	Sep	Oct	Nov	Dec
Total # Intake Workers w/ Under 12 Cases	309	328	299	269	262	272
Total # Intake Workers	530	551	568	582	581	581
% Intake Workers w/ Under 12 Cases	58%	59%	53%	46%	45%	47%
Total Intake Workers w/ Under 8 New Cases	479	388	318	321	372	433
Total Intake Workers	530	551	568	582	581	581
% Workers w/ Under 8 New Cases	90%	70%	56%	55%	64%	75%
# Intake Workers w/ More than 30 Cases	30	23	30	35	33	33

Note: The caseload standard for intake workers changed in July, making the appropriate comparison July, instead of June, to December.

The number of cases open in an investigations unit for more than 60 days (the point at which cases are supposed to be closed or transferred to a permanency unit) was down to 4,688 from 5,926, but this is somewhat misleading, as there was a large decrease from June to July (3,823) due to a one-time effort, and this problem has worsened significantly since then. See Table III below.

Table III: Intake Backlog

	June	July	Aug	Sep	Oct	Nov	Dec
Total open cases intake (CPS & CWS)	10,029	6,915	6,881	7,917	8,568	8,834	8,793
Open more than 60 days	5,926	3,823	3,714	3,618	3,738	4,117	4,688
% open more than 60 days	59%	55%	54%	46%	44%	47%	53%
% open less than 60 Days	41%	45%	46%	54%	56%	53%	47%

The turnover rate for front-line caseworkers due to separations was 14% annually, comparable to other systems. In the past year, however, the effective turnover rate for front-line positions was much higher, as many experienced workers switched to other units or were promoted.

Finally, it has become clear that a very large number of the new front-line casework jobs created by the reform plan have been used for non-case carrying positions. In January 2006, DYFS had 2,810 Family Service Specialist positions, an increase of 672 from 2,138 two years earlier. But the number of case-carrying positions increased by only 327 during this period, from 1,710 to 2,037. The remaining 345 new positions were assigned to other tasks (primarily in positions related to resource families, discussed further later in this document).

Other Important Information: (1) Two caseload audits showed significant problems. Workers assigned to other tasks were erroneously reported as permanency workers, inflating the proportion of workers who appeared to have caseloads meeting the standard. New allegations of abuse or neglect on open cases were assigned to intake workers but were not counted on those workers' caseloads. (2) The State's methodology for projecting how many workers it will need to meet standards takes no account of the proportion of workers who are trainees and therefore can not be assigned regular caseloads. (3) A surge in cases being assigned for investigation (see data on this in the State Central Registry section) has created strong upward pressure on caseloads. (4) The status of special case closing efforts is unclear, raising the risk that the effort to safely and appropriately close cases is lagging.

Actions to Consider: (1) Revise reporting and projection methodologies for greater accuracy; the results are almost certain to suggest that the Department has to plan for a larger total number of front-line staff than currently budgeted. (2) Restore the case closing project or develop alternative approach to closing cases that no longer require DYFS involvement. (3) Review the many non-case carrying FSS positions added over the past two years and see if some can be reallocated. (4) Begin development of community programs capable of taking responsibility for some of the clients now on DYFS caseloads who need services but do not need the ongoing involvement of the public child welfare agency. (5) Review the hiring process and identify actions to recruit and hire staff who are more likely to remain (e.g., developing a high quality "day in the life of a caseworker" video) and staff with more experience who will need less time in pre-service training. (6) Address problems at the hotline (see that section for more information).

Training

Overall: Successful implementation of the reform plan requires that priority attention be given to training new workers and retraining existing workers so that they have the knowledge and skills to effectively serve children and families. As of the end of December 2005: (1) A new pre-service curriculum was developed and is in use; it is better than the prior curriculum but still needs improvement. (2) Training for current workers and supervisors is in a development/pilot phase, and both the curriculum and plan for

rolling out the training should be reviewed before proceeding. (3) There is a significant issue regarding the quality and preparation of trainers. (4) The training unit has been asked to carry the burden of transforming practice without either a written practice model or full participation of operations in this major organizational change.

Data: (1) The first 300+ new workers received new pre-service training beginning in August 2005; 125 more are in training now. (2) Nearly 200 supervisors and managers have completed leadership training by the Leadership Training Group (LTG); 120 are currently in training, with 800 more to go. (3) 80 staff received training and were certified by Rutgers University Adoption Certificate Program; a 2-day adoption training course for more than 2,000 staff began in January 2006 and is supposed to be completed by June. (4) 325 staff from 7 counties were trained in Family Team Meetings.

Other Important Information: (1) The new pre-service was rolled out under very difficult circumstances – racing to meet an already delayed deadline. Trainers were frequently asked to learn the material as they had to deliver it, and there was no time for pilot testing the new curriculum. (2) Feedback on the training has been mixed: staff exposed to the strongest and most confident trainers largely found it adequate; others did not. (3) The curriculum still needs to incorporate more skill-building and practice time. The lack of a written practice model also makes it hard for the parts to come together in a coherent whole. (4) Field Training Units have been established in each office to support new workers; this is a positive step, with results again largely dependent on the strength of the individual training supervisor and the amount of support he or she gets from the local office director. (5) Some staff had to wait for pre-service training; others reported difficulty accessing the foundation courses they are required to complete within their first year of work. (6) Staff are working in child protection units without any CPS training. That training was offered once early in 2005, was widely regarded as poor, and has not yet been revised or replaced. (7) The quality of trainers varies widely; some need intensive skill-building, and some need to be replaced. (8) Training for current supervisors and workers is being developed by selecting modules from the pre-service, again under time pressure and without pilot testing, and without customization to take account of the higher experience level of the participants. (9) The Training Academy itself needs to have management positions filled, and to work further on integrating what were historically two separate sets of trainers (in OCS and DYFS).

Actions to Consider: (1) The new DHS/OCS leadership team needs to develop a written practice model that the Training Academy can use as the basis for all curriculum development. (2) Establish a joint training-operations group(s) responsible for developing training and determining how it will be supported in the field, rather than leaving this task solely to the Training Academy. (3) Build more and better training resources by reviewing performance of current training staff, providing additional training time for those who need development, replacing those who should not be training, and adding outside capacity through university contracts. (4) Build time for training trainers and piloting into all implementation schedules. (5) Review and strengthen local office Field Training Units. (6) Fill key management positions in the Training Academy and strengthen its basic management systems (e.g., enrollment and tracking).

Screening and Initial Prompt Response

Overall: The Operations of the State Central Registry (hotline) continue to be highly problematic, with serious negative consequences for almost all other aspects of the system's functioning. As of December 2005: (1) The State Central Registry's current functioning was memorably described by a worker as, "They should stop calling it 'screening' and start calling it 'dispatch,'" and the result has been a crisis in the field as the number of investigations mounted rapidly. (2) Calls are being answered quickly and

(based on reports from caseworkers) more consistently being transferred promptly to the field. However, problems remain regarding the accuracy and completeness of information. (3) Guidelines for screeners remain voluminous and sometimes unclear. (4) There has been repeated management turnover, and the unit is in grave need of stabilization, consistent supervision, and increased accountability.

Data:

It has been difficult to gather accurate data regarding the operations of State Central Registry and investigations. Although there are discrepancies depending on different data sources, all sources show that from spring to summer 2005, there was a significant increase in the total number of investigations and child welfare assessments initiated. The last column in Table IV below shows the best estimate we can provide from the conflicting data sources -- an increase of 26%, from 4,226 referrals in June to 5,331 in October. (In looking at the data in Table IV below, it is important to note that July is historically a low month and that the November and December figures may reflect a lag in data entry.)

Table IV: Reports and Referrals Data Discrepancies

Month	**Reported Total Reports & Referrals**		**CPS Reports**		**CWS Referrals**		**Calculated Total**
Sources	1	3	2	3	3	4	2 & 4
January			2,370			1,062	3,432
February			2,677			830	3,507
March	3,955		3,379			876	4,255
April	4,029		3,550			871	4,421
May	4,039		3,676			882	4,558
June	3,639		3,465			761	4,226
July	2,677	3,449	2,570	2,571	878	597	3,167
August	3,570	4,669	3,621	3,622	1,047	682	4,303
September	4,398	5,669	4,823	4,829	840	457	5,280
October	4,580	5,706	4,909	4,926	780	422	5,331
November	4,334	5,113	4,319	4,342	771	426	4,745
December	3,821	4,538	3,706	3,778	760	422	4,128

Sources: (1) Safe Measures, *Response Priority Compliance – Monthly – Compliance with the response priority level for all CPS and CWS referrals received during the indicated month;* (2) *CPS Reports and Substantiations by Service Application Month.* October through December figures may be understated due to data entry lag; (3) Safe Measures, *Referrals: CPS vs. Non-CPS – Monthly: Breakdown of referrals received during the selected month by CPS or Non-CPS;* (4) *Child Welfare Service Referrals by Service Application Month that Opened a New Case or Reopened a Closed Case.* October through December figures may be understated due to data entry lag; these numbers also do not include referrals for families with existing, open cases. It is also not entirely clear that these numbers represent referrals only or referrals that in fact opened or reopened services (making them more equivalent to a substantiation number than to the report number). The Panel assumes that they represent referrals.

The number of calls received per month fluctuated in the 15,000 – 20,000 range between January and September, the latest month for which we have data. As reflected in Table V below, the increase in investigations has not been driven by an increased volume of calls. Instead, the percentage of calls "screened in" as needing either an investigation or an assessment has increased steadily through the year, from 17% in January to more than 29% in September. We do not have more recent data, but other statistics suggest that there may have been a decrease later in the year. The large majority of these cases are classified as investigations rather than assessments, and the balance has tilted further towards

investigations over the course of the year. Of cases investigated, the substantiation rate has decreased from over 20% in January to less than 16% in August. September data appear even lower but this may be affected by data entry lags.

Table V: State Central Registry (SCR) Volume

Month	Total Calls	Average calls per day	% of calls "screened in" as CPS reports	% of calls "screened in" as CWS referrals	% of calls "screened in" (CPS or CWS)	% of CPS reports substan-tiated
Sources	1	2	3	4	5	6
January	20,598	664	11.51%	5.16%	16.66%	20.5%
February	17,572	628	15.23%	4.72%	19.96%	17.4%
March	19,700	635	17.15%	4.45%	21.60%	16.6%
April	19,590	653	18.12%	4.45%	22.57%	18.4%
May	19,486	629	18.86%	4.53%	23.39%	17.1%
June	17,914	597	19.34%	4.25%	23.59%	16.7%
July	15,586	503	16.49%	3.83%	20.32%	18.6%
August	16,746	540	21.62%	4.07%	25.70%	15.7%
September	18,120	604	26.62%	2.52%	29.14%	10.5%

Sources: (1) *DHS/OCS Quarterly Report to the New Jersey State Legislature*, Quarter Ending September 30, 2005; (2) Original calculation based on data from the *DHS/OCS Quarterly Report to the New Jersey State Legislature*, Quarter Ending September 30, 2005; (3) Original calculation based on data from the *DHS/OCS Quarterly Report to the New Jersey State Legislature*, Quarter Ending September 30, 2005, and *CPS Reports and Substantiations by Service Application Month*; (4) Original calculation based on data from the *DHS/OCS Quarterly Report to the New Jersey State Legislature*, Quarter Ending September 30, 2005, and *Child Welfare Service Referrals by Service Application Month that Opened a New Case or Reopened a Closed Case*; (5) *Child Welfare Service Referrals by Service Application Month that Opened a New Case or Reopened a Closed Case;* (6) *CPS Reports and Substantiations by Service Application Month.* Explanation for 4 and 5: Source data only provides the number of CWS referrals for families who did not already have an existing, open case. Note: September substantiated data may change as investigations are completed.

The percentage of cases abandoned by callers while waiting for a screener to answer decreased steadily from 8.3% in January to 2.6% or less in each month May through September. Average response time was down to 8 seconds by September.

As reflected in Table VI below, data on whether investigations are begun within the required response time are problematic because of large amounts of missing data. For November reports, 37% of investigations were begun on time, 21% not on time, and data are not reported for 42%.

Table VI: Investigation Response Time

Month	In Compliance with Designated Response Time	Not in Compliance	Not Reported	Pending
July	38.6%	36.7%	24.7%	0.0%
Aug	39.7%	36.3%	24.0%	0.0%
Sept	42.6%	33.3%	24.1%	0.0%
Oct	41.0%	26.2%	32.6%	0.2%
Nov	36.6%	21.2%	42.1%	0.1%
Dec	22.2%	14.8%	61.2%	1.8%

Note: These data likely reflect a lag time in data entry.

Other Important Information: (1) Staffing at the hotline appears sufficient and stable – 70 filled screener positions and 14 filled supervisor positions. (2) Policies were changed in September after two high-profile child deaths in cases that had been classified as assessments. Much of the increase in investigations, however, took place in August, before the new policies were put in place. There have been some further modifications in January 2006. On the whole, however, the policies are still not entirely clear, and issues raised by outside evaluators have not consistently been addressed. The Allegation-Based System needs at least to be revised and possibly to be replaced; staff and supervisors need further training. (3) The State added taping capacity and has begun some quality improvement efforts based on review of the tapes of calls to the hotline. (4) Referrals appear to be getting out to the field faster. Staff report referrals with missing information, duplicate case numbers, etc; it is not possible to quantify this or to know whether it is getting better or worse.

Actions to Consider: (1) The State Central Registry (hotline) needs consistent core leadership from capable individuals who will stay there for at least the next 18 months. This is an obvious action, but its importance cannot be overstated. (2) Start using the extensive data now available and the taping system to provide feedback to staff and supervisors and to hold people accountable for performance. (3) Short-run: review multiple sources of information (Hornby-Zeller report, work group, follow up with field staff) on the kinds of allegations that are causing the largest number of problems and develop short-term policy and training changes based on the results. (4) Longer-run: explore screening operations in other states that have successful systems; review outside recommendations to date, with particular attention to whether the Allegation-Based System needs significant modification or replacement; review effects of short-term changes; and develop revised guidance for screeners.

Adoption

Overall: Adoption operations were seriously destabilized in the first year of the reform. As of December 2005: (1) Significant problems remain but, in the prior six months, the State did a creditable job of implementing a stabilization plan. In most of the State, there are now either "mini-ARCs," i.e., a separate adoption unit, or a number of specialized adoption workers within the local office. This structure has been well received by staff. (2) Training of adoption workers is underway, and more children are being assigned to workers with adoption knowledge. (3) However, 20% of children with a goal of adoption still were not on the caseloads of adoption workers or permanency workers who had the support of an adoption specialist. (4) Large numbers of children with a goal of adoption will require a "select" home – i.e., they will not be adopted by their current foster parents – but recruitment of these homes appears to be lagging badly. (5) The longer-term plan for adoption remains unclear.

Data:

As shown below in Table VII, 1,249 adoptions were finalized in calendar year 2005, down 14% from 1,410 in 2004. There were 102 adoptions per month in the first half of the year and 106 per month in the second half.

Table VII: Adoptions Completed

Month	Foster Home	Select Home	Finalized Adoptions
January	82	14	96
February	65	13	78
March	68	7	75
April	84	14	98
May	72	11	83
June			183
July	84	26	110
August	62	18	80
September	96	26	122
October	72	20	92
November	172	19	191
December	35	6	41
2005 Total	894	174	1,249
2004 Total			1,410
2003 Total			Not available
2002 Total			1,266

Of the 3,379 children with a goal of adoption, 771 (about 23%) are at particularly high risk of not making timely progress towards adoption. These children are not on the caseloads of adoption workers or permanency workers who are seeking adoption with the support of an adoption worker. (The remaining 80% are on the caseload of either an adoption worker in a "mini-ARC" or a permanency worker who has an adoption specialist available to help her.)

As of December 31, 2005, there were 2,348 children legally freed for adoption. Nearly half of these children are currently living with families that are expected to adopt them (including families that have not yet signed the legal consent to adoption). The other half either clearly require recruitment of a new adoptive family or have foster parents who have not made a final decision on whether to adopt. As shown below in Table VIII, a surprisingly high number of these children are young.

Table VIII: Children with Adoption as Goal

Age Group	Legally Not Free		Legally Free		Total	
	Number	%	Number	%	Number	%
2 and under	404	39.2%	468	19.9%	872	25.8%
3-5	223	21.6%	598	25.5%	821	24.3%
6-9	190	18.4%	487	20.7%	677	20.0%
10-12	108	10.5%	401	17.1%	509	15.1%
13-15	71	6.9%	290	12.4%	361	10.7%
16-17	31	3.0%	85	3.6%	116	3.4%
18+	4	0.4%	19	0.8%	23	0.7%
Total	1,031		2,348		3,379	

Other Important Information: (1) The State has implemented its three-tiered stabilization plan. 21 local offices (those with the largest adoption caseloads) have "interim adoption units;" 14 with mid-size adoption caseloads have "interim adoption caseloads," i.e., one or more trained adoption workers with primary case responsibility; and 7 with small adoption caseloads have permanency workers handling adoption cases with the assistance of an adoption specialist. (As indicated by the data in the last section, having an adoption unit or worker does not mean that all appropriate cases have been transferred to that unit or worker). (2) Material submitted to the Panel says that there is now a child-specific plan for each child with a goal of adoption, including a recruitment plan for children whose foster parents will not adopt them. None of this material allows us to evaluate whether this is accurate, how good the plans are, or whether they are being implemented. (3) The State has added additional staff and consultants – para-legals, adoption summary writers, and "concurrent planning specialists" (essentially, an adoption expert at the area office level) to support adoption practice. Two area offices did not yet have a concurrent planning specialist by the end of December. (4) Training of all front-line staff on adoption appears to be about three months behind the schedule established in the interim adoption plan; it is now to be completed in June, rather than March, 2006.

Actions to Consider: (1) Identify the barriers to transferring children who should be on adoption caseloads to the appropriate worker, develop strategies to overcome those barriers, and monitor until this problem is resolved. (2) Conduct a CQI audit of a sample of adoption plans, identify the areas in which a significant number of plans are weak, and develop strategies to address the weaknesses. This audit should pay particular attention to whether additional resources (e.g., contracts for child-specific recruitment) are needed. (3) Set targets for adoption progress by office, monitor, and regularly use data to evaluate local performance. Start with a push to finalize adoptions for children who are already legally free and in a pre-adoptive placement. (4) Maintain the three-tiered approach to local adoption practice for at least the next six to twelve months, paying particular attention to those offices which do not yet have sufficient adoption expertise. In transferring cases from permanency workers to adoption workers, try to keep children connected to the permanency workers they have come to know and with whom they have a relationship. (5) Use this period to develop a longer-term adoption plan.

Resource Families

Overall: One of the most important values and elements of New Jersey's reform plan is a commitment to care for children in family settings. As of December 2005: (1) Despite a very substantial investment in resource home recruitment and retention, New Jersey has seen a decrease in the total number of families available to children in out-of-home care. (2) Resource family units in local offices have been staffed up, but there has been little direction provided to them from OCS leadership, and their job responsibilities are unclear. (3) New licensing regulations have been proposed. They incorporate some efforts to make licensing more flexible – particularly for relative caregivers – but rely primarily on a waiver process that is likely to be cumbersome. There is significant fear in the field that good relatives will have to be turned away if these regulations are not modified.

Data:

During FY 2005, New Jersey licensed 922 new resource families, an average of 77/month. For the period July-December 2005, it licensed 443 new families, an average of 73/month. As shown below in Table IX, during this same six month period, 533 licensed families left the system, for a net decrease of 90 resource families. There was also a net loss of 51 relative caregivers during this period.

Table IX: Resource Family Recruitment and Retention

	Jul	Aug	Sep	Oct	Nov	Dec	Jul-Dec	Jan-June	2005 Total
Inquiries (All)	824	952	906	679	671	587	4,619	3,798	8,417
Applications	177	258	310	301	294	352	1,692		
Licensed	63	76	58	79	69	98	443	381	824
Closed	94	90	98	80	106	65	533	454	987
Net Change	-31	-14	-40	-1	-37	33	-90	-73	-163

Foster and Adoptive Family Services (FAFS) surveyed 160 families who made inquiries about becoming resource parents in July 2005, as the State's new "120-day licensing process" was supposed to be getting underway. 23% of the families reported that the State never responded to their inquiry, and another 12% said that the State responded initially but then failed to follow up. Eleven (6.8%) of the families were licensed by the end of November, five months later.

New Jersey has assigned 348 positions to resource family units State-wide; these include support workers, trainers, and recruiters.

Other Important Information: (1) Resource family reimbursement rates rose again as of January 1, 2006; the increase is supposed to be included in checks mailed in February. Inexplicably however, rates have apparently not been raised for SHSP homes (for medically fragile children). (2) Each local office developed a recruitment plan for FY 2006. These plans are now more than six months old, and discussions with recruiters suggested that they have largely not been implemented. Some include targets for the number of families to be added; only a few address the particular populations (e.g., families for teens) or geographic areas to be prioritized. (3) Recruiters report spending most of their time visiting families that have inquired and showing them a Power Point presentation. Some recruiters report that they are not familiar with licensing regulations and are therefore unable to answer even basic questions asked by potential applicants. (4) Resource family support workers report spending most of their time doing homestudies. Some have not been assigned any current resource families to support. There is no clear distinction between what these workers are responsible for and what the caseworker of the children in the home is responsible for. (5) The State selected, customized, and has implemented PRIDE as the resource family training model. Trainers report that, because of pressure to complete applications within 90 days, they are asking families to attend training two or three nights per week, and that some families are withdrawing as a result. (6) There have been some efforts to provide data to local areas for use in developing recruitment plans but these have been used unevenly and without guidance from the central office. (7) New licensing requirements (scheduled to go into effect February 2006) put the burden on applicants to seek waivers, rather than providing flexibility for licensing staff to take into account all of the circumstances in making a licensing decision. (8) Flexible funds have been made available to support resource families. Data received by the Panel to date on the use of these funds are unclear and do not permit an analysis of how often and how well they are used. (9) There has been considerable turnover in a variety of resource family related positions in central office and a lack of consistent leadership in this area.

Actions to Consider: (1) Assign a strong State-wide leader to this work. Charge this person with, in consultation with staff in the field: (a) developing clear job responsibilities for each of the new staff types; (b) identifying training needs for resource family staff and determining how these can be met; and (c)

creating a new framework for local recruitment plans and a process by which those plans will be reviewed, locally and centrally, and either adopted or sent back for revision. (2) Assign or contract for a careful data analysis of (a) where the existing resource families are located and what kinds of children they will accept; (b) where children are coming into care and with what kinds of special needs; and (c) what these figures imply for State-wide and local recruitment goals. Provide the results to staff developing recruitment plans. (3) Strengthen the recruitment function by bringing in outside consultants to work on local recruitment plans and build the skills of the recruiters. (4) Develop modifications to the new licensing regulations designed to increase flexibility, particularly for relative caregivers. (5) Clarify that the purpose of the new licensing process is to provide better customer service, not to impose arbitrary deadlines on applicants, and that completion of the process within 120 (not 90) days is encouraged but not required.

Medical Services

Overall: The State is able to supply very little information about the medical care provided to children in foster care. As of December 2005: (1) The State has not provided an update showing progress against the medical plan developed nearly a year ago. (2) Multiple sources of information suggest that, while virtually all children entering out-of-home care get a pre-placement physical examination, only a minority get a comprehensive health and mental health exam. There seem to be similar, serious problems with regard to follow-up care and immunization status. (3) The available data are weak, and the State does not have an effective mechanism for knowing how many children are getting appropriate medical care, nor for tracking the care of individual children.

Data:

An audit done by OCS indicates that more than 99% of children entering out-of-home care had a pre-placement medical examination. 49% of these took place in a hospital emergency room, up from approximately 40% in April 2005.

A minority of children entering care receive a comprehensive medical and mental health exam ("CHEC"). The Office of the Child Advocate reported the figure at about 20%; OCS has submitted a figure of approximately 35% for July through September in its PIP update to the Federal government. The State provided information on EPSDT compliance, but it is extremely out-of-date (it covers a period ending June 2004) and acknowledged to be unreliable. It shows that, of the children who should have had at least one EPSDT visit during the year, only 37% did so. The State has also provided results of a 26-case, "pilot audit" conducted in just two offices very recently. As seen in Table X below, it shows results ranging (roughly) from 60% of children getting their immunizations to 80% getting a physical exam and follow-up treatment.

Table X: Results from 26-Case Medical Case Audit

Indicator	%	N
Evidence of an annual physical health exam for children 25 months of age or older	66%	6
Evidence of a physical health exam according to the prescribed periodicity schedule for children 24 months of age and under	80%	20
Evidence of at least partial follow-up identified health treatment needs	81%	26
Dental visits for children 3 years of age and over;	83%	18
Follow-up of dental recommendations	42%	18
Evidence of immunizations in Case File (overall)	61%	26
birth to 3 years	100%	10
4 to 10 years	63%	6
11 years and older	62%	10

Note: Because of the extremely small sample size (N ranging from 6 to 26), these statistics are not statistically valid and may not be meaningful

Quality Service Reviews conducted in four counties have also provided slightly more encouraging news on medical care. They show – again with a very limited sample size of about a total of 70 cases – a range from 79% to 96% of children receiving at least "acceptable" health services. Other than these small samples, the State has been simply unable to provide information showing how many children are receiving follow-up medical care, dental care, etc.

Other Important Information: (1) The relationship between the Office of the Medical Director and the remainder of OCS has been troubled, and lines of authority with regard to important parts of the medical plan remain unclear. (2) The division of responsibility for follow-up on medical issues – as between foster parents, caseworkers, and local office nurses – also remains unclear. (3) OCS has acknowledged that the limited number of organizations with contracts to provide CHECs is insufficient to meet demand. Some efforts to create additional contracts are underway. (4) The strategy of enrolling virtually all children in HMOs has not been reviewed to determine its effects on medical care. (5) Current practices appear at odds with the desire to provide for continuity of medical care. Children entering care who have an existing relationship with a pediatrician may nevertheless have to see a different doctor if their old doctor is not in the HMO to which they are assigned. Children leaving care may similarly have to switch doctors. (6) As is evident from the data above, data sources are weak, and timely information about medical care is not available. Materials submitted to the Panel suggest that very recently local offices were provided with access to Medicaid information; we do not know to what extent they are able to make use of this information.

Actions to Consider: (1) Clarify the responsibilities and authority of the Medical Director, the role and reporting relationships of the nurses in the local offices, and the relationship between the Medical Director and the behavioral health system. (2) Review the medical plan, with the assistance of outside consultants if necessary, identify the critical actions needed in the short run to provide basic medical care, and focus attention on those actions first. (3) Modify the CHEC process and make comprehensive examinations available at a wider number of qualifying health providers to expand access and timeliness.